

Office Use Only

Approval Date _____

Approved by _____

Fee _____ Date _____

Approved by _____

Permit No. _____ Date _____

**APPLICATION FOR CONSCIOUS/ENTERAL SEDATION PERMIT
KENTUCKY BOARD OF DENTISTRY
10101 LINN STATION ROAD, STE 540
LOUISVILLE, KENTUCKY 40223**

THIS PERMIT WILL ALLOW YOU TO ADMINISTER CONSCIOUS/ENTERAL SEDATION.

Reference: KAR 8:390 Section 3 and Section 2(8).

This completed application must be accompanied by a check in the amount of \$30.00 payable to the Kentucky Board of Dentistry. The form must be completed carefully and sworn to before a Notary Public. Form should be returned to the Kentucky Board of Dentistry with the proper documentation at the above address.

NAME _____ KY LICENSE NO. _____

OFFICE ADDRESS _____ PHONE: _____

CITY, STATE, ZIPCODE _____

A short resume showing evidence of your qualifications must accompany this application with a detailed listing of all dental, professional, and post-doctoral education supporting these qualifications, including dates attended with copies of supporting documents.

_____ A. Completion of an approved course in conscious sedation with parenteral drugs in a program approved by the Kentucky Board of Dentistry. Include documentation of having treated 25 cases. Submit copies of anesthesia/conscious sedation record of twenty-five patients for which you had primary responsibility. Record should include patients' name, date of procedure, procedure(s) performed, anesthetic management, including drugs, doses, vital signs and complications.

_____ B. Diplomate, board eligible, or eligible for board examination in any specialty, or a graduate of an accredited general practice residency. Provide proof of training in the use of conscious sedation with parenteral drugs.

All dentists administering conscious sedation with parenteral drugs must be certified in basic life support (BLS). **A copy of the front and back of the BLS card must accompany this application.** BLS Certificate Date _____

All staff assisting with conscious sedation with parenteral drugs must be certified in basic life support (BLS).

A copy of the front and back of the BLS card must accompany this application. BLS Certificate Date _____

I hereby certify that the above facts are true and I agree to abide by the rules and regulations set by the Kentucky Board of Dentistry including any future amendments to said rules and regulations.

Applicant's Signature

State of _____

County of _____

Subscribed and sworn to before me this _____ day of _____, 20_____

(Seal)

Notary Public signature

My commission expires on _____

REV 04/02